

Radiation Treatment

2009 CODING & REIMBURSEMENT GUIDE

Facility Payment
Location: Hospital Outpatient

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® CODE ¹	DESCRIPTION	APC ²	STATUS INDICATOR ³	2009 NATIONAL AVERAGE MEDICARE RATE ^{2,4}
76950	Ultrasonic guidance for placement of radiation therapy fields	268	N	Packaged
76965	Ultrasonic guidance for interstitial radioelement application	309	N	Packaged
77014	Computed tomography guidance for placement of radiation therapy fields	282	N	Packaged
77290	Therapeutic radiology simulation-aided field setting; complex	305	X	\$255.69
77295*	Therapeutic radiology simulation-aided field setting; 3-dimensional	310	X	\$892.90
77326	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy 1 to 8 sources)	304	X	\$114.70
77336 (per 5 fractions)	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, report per week of therapy	304	X	\$114.70
77370	Special medical radiation physics consultation	304	X	\$114.70
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	299	S	\$373.21

*Medicare's National Correct Coding Initiative includes edits that will not permit payment for 77014 or 77290 if either of these codes are reported by the same physician for the same patient on the same date of service when 77295 is reported

Treatment Delivery

CPT® CODE ¹	DESCRIPTION	APC ²	STATUS INDICATOR ³	2009 NATIONAL AVERAGE MEDICARE RATE ^{2,4}
77280 (per day of treatment)	Therapeutic radiology simulation-aided field setting; simple	304	X	\$114.70
77300 (per fraction)	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	304	X	\$114.70
77785 **(per fraction)	Remote afterloading high intensity brachytherapy; 1 channel	313	S	\$733.25
77786 **(per fraction)	2-12 channels	313	S	\$733.25
77799	Unlisted procedure, clinical brachytherapy *may consider reporting for catheter removal	312	S	\$430.66
C1717	Brachytherapy source, high dose rate iridium 192, per source	1717	U	Paid on cost basis

** Multiple treatment sessions on the same day are generally payable as long as there has been a distinct break between therapy services and the individual sessions are of the character usually furnished on different days. When billing more than one (1) treatment session on the same date of service, the first treatment may be coded with the appropriate treatment delivery code and the second may be coded again on a separate line with a -59 modifier. Policies for use of modifiers vary by carrier/health plan/payer so please check your local organizations for specific guidelines.

Modifier Information⁵

MODIFIER	DESCRIPTION	EXPLANATION
76	Distinct Procedural Service	Modifier 76 Repeat procedure by same physician.

1. American Medical Association, CPT® 2007, Professional Edition and HCPCS 2007, Nineteenth edition.

2. Ambulatory Payment classification (APC) payment rate is based upon the CMS Hospital Outpatient Prospective Payment System final rule published in the Federal Register, October 30, 2008.

3. Status Indicators referenced in upon the CMS Hospital Outpatient Prospective Payment System final rule published in the Federal Register, October 30, 2008.

4. Physician relative value units (RVUs) are based on the Medicare 2009 Physician Fee Schedule Final Rule published in the Federal Register, October 30, 2008. National Average Medicare rates, rounded to the nearest dollar, are based on these RVUs and account for the work RVU adjustment completed by CMS for Medicare budget neutrality purposes. The 2009 conversion factor is \$36.067. Actual payment to a physician will vary based on geographic location. Payment for a given procedure in a given locality is available in the Medicare Physician Fee Schedule Look-up file posted on the Physician Center of the CMS website.

5. Modifier Information is taken from, Coding with Modifiers, A Guide to Correct CPT and HCPCS Level 11 Modifier Usage, 2004 American Medical Association, Second Printing July 2004, Third Printing February 2005.

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Physician Payment
Location: Hospital Outpatient

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® CODE¹	DESCRIPTION	RVU⁴	2009 NATIONAL AVERAGE MEDICARE RATE²,⁴
76950-26	Ultrasonic guidance for placement of radiation therapy fields	.81	\$29.21
76965-26	Ultrasonic guidance for interstitial radioelement application	1.93	\$69.61
77014-26	Computed tomography guidance for placement of radiation therapy fields	1.18	\$42.56
77263-26	Therapeutic radiology, treatment planning; complex	4.38	\$158.33
77290-26	Therapeutic radiology simulation-aided field setting; complex	2.17	\$78.26
77295-26*	Therapeutic radiology simulation-aided field setting; 3-dimensional	6.34	\$228.66
77326-26	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy 1 to 8 sources)	1.29	\$46.53
77470-26	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	2.91	\$104.95

* Medicare's National Correct Coding Initiative includes edits that will not permit payment for 77014 or 77290 if either of these codes are reported by the same physician for the same patient on the same date of service when 77295 is reported

Treatment Delivery

CPT® CODE¹	DESCRIPTION	RVU⁴	2009 NATIONAL AVERAGE MEDICARE RATE²,⁴
77280-26 (per day of treatment)	Therapeutic radiology simulation-aided field setting; simple	.98	\$35.35
77300-26 (per fraction)	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	.86	\$31.02
77785 **(per fraction)	Remote afterloading high intensity brachytherapy; 1 channel	1.98	\$71.41
77786 **(per fraction)	2-12 channels	4.46	\$160.86
77799-26	Unlisted procedure, clinical brachytherapy *may consider reporting for catheter removal	Status Code C	Carrier/payer prices code. RVU's and payment amounts may be established for these services following review of documentation

** Multiple treatment sessions on the same day are generally payable as long as there has been a distinct break between therapy services and the individual sessions are of the character usually furnished on different days. When billing more than one (1) treatment session on the same date of service, the first treatment may be coded with the appropriate treatment delivery code and the second may be coded again on a separate line with a 76 modifier. Policies for use of modifiers vary by carrier/health plan/payer so please check with these organizations for specific guidelines.

Modifier Information⁵

MODIFIER	DESCRIPTION	EXPLANATION
26	Professional component	Certain procedures are a combination of a physician component and a technical; component. When the physician component is reported separately, the service may be identified by adding a modifier 26 to the usual procedure number
76	Distinct Procedural Service	Repeat procedure by same physician

RVUs and National Average Medicare Rates for codes listed with modifier -26 are based on the professional component of the service only. Physicians may not bill for the technical component of a service (or the global service since it includes the technical component) that is provided in a hospital setting because Medicare pays the hospital for these services through the APC payment methodology.

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